State Health Benefit Plan

MANAGED MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2006

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This document printed in May, 2006 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY STATE HEALTH BENEFIT PLAN WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

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Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

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- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

Notice Regarding Emergency Services And Urgent Care

In the event of an Emergency, get help immediately. Go to the nearest emergency room, the nearest Hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a Hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call 24 hours a day, seven days a week to assist you when you need Emergency Services.

If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization may arrange to have you transferred to a Participating Provider for continuing or follow-up care, if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area

For Urgent Care inside the service area, you must take all reasonable steps to contact your PCP for direction and you must receive care from a Participating Provider, unless

otherwise authorized by your PCP or the Review Organization.

Urgent Care Outside the Service Area

In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP or the CIGNA HealthCare 24-Hour Health Information Line for direction and authorization prior to receiving services.

Continuing or Follow-up Treatment

Continuing or follow-up treatment, whether in or out of the service area is not covered unless it is provided or arranged for by your PCP or upon prior authorization by the Review Organization.

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Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

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Coverage for Reconstructive Surgery Following Mastectomy

When a person who is insured for benefits under this certificate and who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your Employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOT101

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers/Pharmacies, you will automatically and without charge, receive a separate listing of Participating Providers/Pharmacies.

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with CIGNA HealthCare.

NOT88

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to

102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

NOT141

Reinstatement of Benefits (Applicable To All Coverages)

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

NOT142

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the social security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

GM6000 NOT99

Important Notices

NOTICE:
TO RECEIVE BENEFITS AT THE LEVEL SHOWN IN THIS POLICY, SERVICES MUST BE PROVIDED BY A PARTICIPATING PROVIDER, UNLESS SPECIFICALLY STATED TO THE CONTRARY IN THE CERTIFICATE.

NOT1V7

Effect of Section 125 Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet Special Enrollment criteria per federal requirements as described in the Section entitled "Eligibility – Effective Date/Exception to Late Entrant Definition"; or
- the date you meet criteria shown in the section entitled "Change of Status."

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Qualifying Events that Allow Coverage Changes for Active Employees

If you are actively employed and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the event. The following chart shows qualifying events and the corresponding changes that active Employees can make.

Qualifying Events that Allow Coverage Changes for Active Employees	
If you have one of these events	**Within 31 days of event, you may:**
Marriage	• Enroll • Change to family coverage • Discontinue coverage; letter from other plan documenting your coverage is required. Certified copy of marriage certificate is required
Birth, adoption or legal guardianship	• Enroll • Change to family coverage Certified copy of birth or adoption certificate is required

You lose coverage because you divorce	• Enroll in any CIGNA option offered by the SHBP • Change your coverage type Copy of divorce decree and loss of coverage documentation is required
You or your spouse loses coverage through other employment	• Change to family coverage Letter from other employer documenting loss is required
You, your spouse or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid or Medicare	• Enroll in single or family coverage • Change to any available CIGNA option offered by the SHBP Letter from other employer, Medicaid or Medicare documenting time and reason for loss or discontinuation is required
Your spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified plan	• Change to single coverage • Discontinue coverage Letter from other employer documenting effect on coverage eligibility is required.
Your former spouse loses coverage or plan is cancelled, resulting in loss of your dependent children's coverage	• Enroll in any available CIGNA option offered by SHBP • Change to family coverage Letter from other plan documenting loss is required
You acquire new coverage under your spouse's employer's plan	• Change to single coverage • Discontinue coverage – you must document your spouse's coverage and current coverage for all dependents previously covered by your SHBP coverage. Letter from other plan documenting your coverage is required
Your spouse makes an Open Enrollment change under your spouse's employer's plan, creating an overlap or break in coverage because your spouse's coverage has a different plan year.	• Enroll • Change to single coverage • Discontinue your coverage – you must document your spouse's coverage Letter from other plan documenting overlap or break in coverage is required.

You, your spouse or enrolled dependent moves out of your Plan's service area	• Change to any available option offered by SHBP • Discontinue coverage – documentation of change in residence may be required.
The CIGNA option for which you are enrolled goes out of operation	• Change to any available option offered by SHBP. You must file your Membership Form within 31 days.
You or your spouse is activated into military reservist service	• Enroll in any CIGNA option • Change coverage type Copy of orders is required.
You retire and immediately qualify for a retirement annuity	• Change to any CIGNA option offered by SHBP when you retire You must complete and submit Plan enrollment form no later than 60 days after leaving active employment.
Qualifying Events that Allow Coverage Changes for Active Employees (Continued)	
You, your spouse or all enrolled dependents become eligible for Medicare or Medicaid.	• Discontinue your coverage • Change to single coverage – if you are retired and you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage. Letter from Medicaid or Medicare documenting eligibility is required. • Retirees may change to any available option offered by SHBP upon becoming eligible for Medicare coverage.

If you lose all your covered dependents because of death, divorce, marriage of dependent, age, loss of full-time student status or other qualifying reason, you have 90 days from the date of the event to complete the necessary form(s) to request a change from family to single coverage.

How to Request a Change

During Open Enrollment and the Retiree Option Change Period, Members can go online to make coverage changes for the upcoming Plan Year. See the Health Plan Decision Guide for Web addresses and instructions. If you do not have

Internet access or if your request is in the middle of a Plan year, then:

- **Notify your personnel/payroll office:** Ask for the *Membership Form* and other required forms. If you are retired, contact the SHBP eligibility unit directly or your former employer's personnel office.
- **Return completed forms** with requested documentation to your personnel/payroll office, the SHBP or your retirement system. You must make change by the appropriate deadline.

If you miss the deadline, you won't be able to make your change until the next Open Enrollment Period. Changes permitted for retirees are limited, please refer to the retiree section for more details.

How To File Your Claim

When you or your Dependents seek care through a Participating Provider, you are only responsible for the applicable copayment, coinsurance or deductible amount shown in the Schedule. You do not need to file a claim form.

If you or your Dependents seek care through a Non-Participating Provider, you must submit a claim form to be reimbursed.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Eligibility — Effective Date

The State Health Benefit Plan determines who is eligible to enroll.

Waiting Period

Initial Employee Group: None.

New Employee Group: The first of the month following one calendar month of employment

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Employee Insurance

This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Eligibility for Employee Insurance

You are eligible to enroll yourself and your eligible dependents for coverage if you are:

- A full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration, or a contracted employer that participates in the SHBP, as long as:
  - you work at least 30 hours a week consistently, and
  - your employment is expected to last at least nine months.
- a certified public school teacher or library employee who works half-time or more, but not less than 18 hours a week.
- a non-certified service employee of a local school system who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week.
- An employee who is eligible to participate in the Public School Employees' Retirement System as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week.
- A retired employee of one of these listed groups who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. (See Provisions for Eligible Retirees for details of retiree medical coverage.)
- An employee in other groups as defined by law.

You are not eligible if you are:

- a student employee for seasonal, part-time, or short-term employees.
- a temporary or emergency employees.

Eligibility for Dependent Insurance

The State Health Benefit Plan determines who is eligible to enroll.

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Eligible dependents are:

- Your legally married spouse
- Your never-married dependent children who are:
  1. Natural or legally adopted children under age 19, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody.
  2. Stepchildren under age 19 who live with you at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents.
  3. Other children under 19 if they live with you permanently and legally depend on you for financial support — as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction.

- Your natural children, legally adopted children or stepchildren 19 or older from categories 1 and 2 above who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19.
- Your natural children, legally adopted children, stepchildren or other children ages 19 to 26 from categories 1, 2 and 3 above who are registered full-time students at fully accredited schools, colleges, universities, or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time student status is defined by the school in which the child is enrolled.

When requested by the Plan, you will be required to provide documents such as a marriage license, birth certificate, adoption contract or judge-signed court order to verify your dependent relationship. The Plan has the right to determine whether or not the documentation satisfies Plan requirements. If verification cannot be made, the dependent's coverage will be terminated retroactively to his or her coverage effective date. The Plan will make every effort allowable under the law to recover from the employee any and all payments made by the Plan on behalf of an ineligible dependent.

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Documentation Required for Eligible Covered Dependents Age 19 or Older

Coverage does not continue automatically at age 19. The information above describes what you must do to request continued coverage as your child nears age 19.

Eligibility for Dependent Insurance
Documentation Required For Eligible Covered Dependents Age 19 or Older

Coverage does not continue automatically at age 19. This chart describes what you must do to request continued coverage as your child nears age 19.

For a Covered Dependent Age 19 and older	You Must
….and a Full-time Student under the age of 26	Update the SHBP annually on student status by requesting a certification letter from the school's registrar and sending it with a Dependent Student Status Information Form to the SHBP. The certification letter must include: • enrollment date(s) for both current and previous quarters or semesters; and • number of credit-hours taken each quarter or semester • enrollment status (full or part time) for each quarter or semester
….and disabled as a covered SHBP member before age 19	File a written request for continuation of coverage prior to the 19th birthday or within 90 days after the 19th birthday and provide satisfactory documentation of disability.

If you have a disabled child who is already age 19 when you enroll, the child is not eligible for coverage. However, if your disabled child loses coverage under another plan, you may

apply for SHBP coverage on the child if you were eligible for SHBP coverage on your child's 19th birthday. To apply, send the Plan a written request and documentation on your child's disability and loss of other coverage within 90 days of the dependent's loss of coverage. You must be covered under the Plan when application is made.

A general note regarding documentation sent to the Plan. While the Plan requires that coverage requests are made within a specific time period, the documentation required to support your request may be filed later, if necessary, within 60 days following the deadline to file the coverage requested.

Who's Not Eligible For Dependent Coverage

The most common examples of persons not eligible for SHBP dependent coverage include:

- Your former spouse
- Your fiancé
- Your parents
- Married or formerly married children
- Children age 19 or older who do not qualify as Full-time Students or disabled dependents
- Children 26 or older who are not already covered as a disabled dependent
- Children in military service
- Grandchildren who cannot be considered eligible dependents
- Stepchildren who do not live in your home at least 180 days per year.
- Anyone living in your home that is not related by marriage or birth, unless otherwise noted

Enrolling for Coverage and When Coverage Begins

You must enroll to have SHBP coverage. To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option
- Select either single coverage or family coverage
- Name the eligible dependents you want to cover

Your signature on the enrollment form authorizes periodic payroll deductions for premiums. Your employer may also ask you to complete other forms. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualifying event under Section 125 of the Internal Revenue Code, which restricts mid-year changes in the SHBP.

Special Note: If you terminate employment and are re-hired during the same Plan year, you must enroll in the same Plan option, provided you are eligible for that option.

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- You - the contract/policyholder
- Member - You and/or your eligible dependents that you choose to enroll

Where appropriate, this SPD relies on these terms throughout the document:

- Employee, retiree or Member . to refer to a participant
- Dependent(s) to refer to Member

Eligibility - Effective Date

When You Can Enroll

If you are:	You can enroll:	Your coverage takes effect:
A current Employee	• Or make coverage changes during Open Enrollment • Or make coverage changes within 31 days of a qualifying event; upon loss of all eligible dependents, within 90 days	The upcoming January 1 First of the month following request
A newly hired Employee	Within 31 days of your hire date	First of the month after a full calendar month of employment

If You Have Coverage through a Different Health Plan

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date. You may not enroll until the next Open Enrollment period unless you have a qualifying event.

Qualifying Events

You can make changes to your coverage if you have a qualifying event. The coverage change must be consistent with the qualifying event.

If you have this event…	You may…
Within 31 days of eligibility for retiree coverage Annuity no longer covers premium amount Become eligible for Medicare	Change to an available option
Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) Within 31 days of loss of a dependent's health benefit coverage through spouse's or former spouse's Medicaid, Medicare, group or COBRA coverage	Change from single to family coverage* Proper documentation required. **Surviving spouses and dependents cannot change from single to family coverage.*
Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	Change coverage type within 31 days of the qualifying event; proper documentation is required
You and spouse are both retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted	Change at any time from family coverage to each having single coverage; a request to change from family to single for you and the request for single coverage for your spouse must be filed at the same time

You must request a coverage change within 31 days of the qualifying event by:

- Contacting the Plan directly
- Returning the necessary form(s) with any requested documentation to the Plan by the deadline. Fill out the form(s) completely.

If you miss the deadline, you will not have another chance to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request.

Changes Permitted Without a Qualifying Event

Retirees may change from family to single coverage, or discontinue coverage at anytime by submitting the appropriate Plan form. However, if you change from family to single coverage, you cannot increase your coverage later without a qualifying event. Also, if you discontinued coverage, you may not enroll later.

Important Note on Coverage Changes: If your current Plan option is not offered in the upcoming Plan Year and you do not elect a different option available to you during the Retiree Option Change Period, your coverage will be transferred automatically to the PPO Option effective January 1 of the subsequent Plan Year.

Eligibility - Effective Date

Enrolling a Newly Eligible Dependent

If you have a new dependent due to marriage, birth or adoption, you may enroll your dependent if you request enrollment within 31 days of the marriage, birth or adoption.

This next chart describes what you will need to do if you wish to add a newly eligible dependent,

If you have to enroll a newly eligible dependent and	You will need to:
…you already have family coverage	• File a Dependent/ Miscellaneous Update Form with the SHBP within 31 days of the birth, marriage or adoption placement
…you do not have family coverage	• Change your coverage type to family * by filing a Membership Form with your personnel/payroll office within 31 days of the birth, marriage or adoption placement
…you have a court order requiring you to enroll dependent child(ren), such as a QMCSO	• Enroll the eligible child(ren); coverage starts on first day of month following the request • Change to family coverage if you have single coverage.

*To make coverage retroactive to the child's birth or placement, you must make family coverage premium payment coverage for the month of the birth or adoption

contract and placement.

Identification Cards

After you enroll, you will receive an identification (ID) card and an ID card for yourself and eligible dependent(s), if applicable. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of enrollment you should contact CIGNA Member Services at 800-244-6224 or www.mycigna.com to replace lost or stolen ID cards.

Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Employer for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not receive these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

The Employer, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

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Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

A. Eligibility for Coverage Under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Orders

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by the provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

You may make coverage changes as shown below during the Plan Year when you receive a Qualified Medical Child Support Order (QMCSO).

If a QMCSO requires	You can file a Membership Form to:
…you to provide coverage for your natural child(ren)	• Enroll or change from single coverage to family coverage – there is no time limit for this change; documentation of the court order is required.
…your former spouse to provide coverage for each of your enrolled natural child(ren)	• Change from family to single coverage – within 90 days of the court ordered date; documentation of the court order and the other coverage is required.

Generally, a change in coverage takes effect the first of the month following receipt of the change request.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type

or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with state laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Other Dependents

When you select family coverage as a new employee, dependent coverage begins when your coverage begins. If you add dependents later, coverage takes effect as described in the chart below:

If you add this dependent	Coverage takes effect:
A baby	• On the first day of the month following the request; or • On the day your child was born, if the family premium is paid from the birth month.* Copy of certified birth certificate is required upon request
An adopted child	When you already have family coverage: • on the date of legal placement and physical custody When you change to family coverage within 31 days of the event: • on the date of legal placement and physical custody, if the family premium is paid from the time of placement and custody * Copy of certified adoption certificate is required upon request
A new spouse	When you already have family coverage: • on the day of your marriage When you have single coverage: • on the first day of the month following the request Copy of certified marriage certificate is required

* If necessary, you may change to family coverage before the birth to avoid retroactive premium payments.

You must enroll for dependent coverage and submit the required form(s) within 31 days of the birth, adoption, or marriage.

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When Coverage Ends

For You

Your coverage generally will end if:

- you no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased
- you do not make direct-pay premium payments on time
- you resign or otherwise end your employment
- you are laid off because of a formal plan to reduce staff
- your hours are reduced so that you are no longer benefits eligible
- you do not return to active work after an approved unpaid leave of absence
- you are terminated by your employer

Coverage for you ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay.

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An enrolled dependent's coverage ends on the date the Participant's coverage ends.

Eligibility - Effective Date

When Coverage Ends

Coverage will end when you discontinue coverage or fail to pay premiums on time.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- You change from family to single coverage
- You do not pay premiums on time
- Your coverage as a Participant ends

Keep in mind that if you drop dependents from your coverage, you will *not* be able to enroll them again – unless you have a qualifying event.

Situation	Effect on Coverage
• If enrolled dependent is a stepchild under age 19 and does not meet the 180 day residency requirement	Coverage ends at the end of the month in which dependent moves out
• If enrolled dependent is a Full-time Student at an accredited college, university or other institution.	Coverage ends on the last day of the month in which the earliest of these events occurs: • Graduation or completion of requirements if graduation is delayed • Full time attendance ends – unless child has attended previous two consecutive semesters and plans to return after a one semester break • Dependent reaches age 26 • Dependent marries • Dependent becomes employed in a benefits eligible position
• If you or your spouse or eligible dependent(s) lose other group health insurance coverage because of change in employment	• Before you lose coverage or within 31 days after losing coverage, file your request for SHBP coverage, which will start on the first day of the month following the request.
• If you divorce and your spouse loses coverage as your dependent.	• Coverage ends at the end of the month in which the divorce becomes final.
• If you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage.	• You may enroll yourself or your family if you request this coverage within 31 days of the event.

Retiree Option Change Period

During the 30-day Retiree Option Change Period – generally from mid-October to mid-November each Plan Year – you can make these changes to your coverage:

- Select a new coverage option
- Change from family to single coverage
- Discontinue coverage (Note that re-enrollments are not allowed.)

Changes will take effect the following January 1.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options
- Steps for notifying the Plan about coverage selections for the new Plan Year
- Forms you may need to complete
- Informational resources

To ensure that you receive the information packet, make sure the Plan always has your most up-to-date mailing address.

If you Return to Active Service

If you choose to return to Active Service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an Active Employee and through the payroll deduction by your employer. You will need to complete enrollment paperwork with your Employer and the appropriate form to have the deduction stopped with the retirement system.

When you return to retire status, retiree coverage may be reinstated after notifying the Plan within 60 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree. Under Georgia law the SHBP is required to subordinate health benefits to Medicare benefits.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to retiree Plan coverage – unless the final service period qualifies you

for a retirement benefit from a state-supported retirement system.

Provisions for Eligible Retirees – and Consideration for Participants near Retirement

Plan Membership

This section includes Plan Membership and co-ordination of benefits information for eligible retirees as well as important points to consider if you are near retirement. Effective January 1, 2006 SHBP will implement a new Medicare policy. SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes.

Eligibility

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these systems:

- Employees' Retirement System
- Teachers' Retirement System
- Public School Employees' Retirement System
- Local School System Teachers' Retirement System
- Fulton County Retirement System (eligible members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who have withdrawn money from their respective retirement system will not be able to continue health coverage as a retiree. Eligibility for temporary extended coverage under COBRA provisions would apply.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will select a Primary Care Physician for yourself and your Dependents from a list provided by CG. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician.

Direct Access for Ob/Gyn Services:

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered ob/gyn services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

GM6000 FLX143 V35

Direct Access for Managed Vision Care

Medically necessary eyecare for Injury or Illness will not require prior authorization from your Primary Care Physician.

Direct Access for Dermatological Services

You and/or your Dependent may receive care for services rendered by a dermatologist without prior authorization from a Primary Care Physician.

GM6000 FLX142V12

Direct Access For Chiropractic Care Services:

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for In-Network covered Chiropractic Care services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for Chiropractic Care.

GM6000 FLX143 V36

Direct Access For Mental Health And Substance Abuse Services:

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Abuse Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Abuse.

GM6000 FLX142 V57

Applying for Coverage Continuation

If you are an eligible retiree, you must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your active coverage ends. Application can be made on a *Retirement/Surviving Spouse Form,* available through your personnel/payroll office or by contact the Plan's Eligibility Section. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.**

When Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage starts immediately at retirement, provided that you make proper premium payments or have them deducted from your annuity check. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your retiree coverage begins. A change from single to family coverage as a retiree is allowed only when you have a qualifying event.

Managed Medical Benefits

The Schedule

For You and Your Dependents

Managed Medical Benefits provide coverage for care In-Network. To receive Managed Medical Benefits,

You and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-network benefit level.

Coinsurance
The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments/Deductibles
Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further medical deductible for the rest of that year.

Out of Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for charges for which no payment is provided because of the coinsurance factor and the plan deductible. However, charges for Covered Expenses incurred for or in connection with a) Mental Health and Substance Abuse b) non-compliance penalties, or c) in excess of Maximum Reimbursable Charge levels will not accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will not be increased. Once the out-of-pocket maximum as shown in The Schedule has been reached, benefits for accident or sickness are payable at 100% excluding mental health and substance abuse benefits.

Contract Year
Contract Year means a twelve month period beginning on each 01/01.

Guest Privileges
If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon
The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	$2,000,000
Coinsurance Levels	90%
Contract Year Deductible Individual Family Maximum	 $200 per person $400 per family
Out-of-Pocket Maximum Individual Family Maximum Includes Coinsurance Includes Deductible Includes Copays	 $1,000 per person $2,000 per family Yes Yes No
Physician's Services Primary Care Physician's Office visit Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB/GYN provider is considered a Specialist. Surgery Performed In the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections Allergy Serum (dispensed by the physician in the office)	 No charge after $20 per office visit copay; No charge if only x-ray and/or lab services performed and billed. No charge after $25 per office visit copay; No charge if only x-ray and/or lab services performed and billed. No charge after $20 Physician or $25 Specialist per office visit copay No charge after $20 Physician or $25 Specialist per office visit copay No charge after $20 Physician or $25 Specialist per office visit copay or the actual charge, whichever is less No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Preventive Care Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (including immunizations) **Note:** Well-Woman OB/GYN visits will be considered a Specialist visit. Immunizations	No charge after $20 Physician or $25 Specialist per office visit copay No charge
Mammograms, PSA, PAP Smear Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine")	 No charge **Note:** The associated wellness exam is subject to the PCP or Specialist per office visit copay Subject to the plan's x-ray & lab benefit; based on place of service
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	90% after plan deductible Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room.	 90% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK
Emergency and Urgent Care Services	
Physician's Office	No charge after $20 Physician or $25 Specialist per office visit copay
Hospital Emergency Room	No charge after $100 per visit copay** (Copay waived if admitted)
Outpatient Professional Services (radiology, pathology, ER physician)	No charge
Urgent Care Facility or Outpatient Facility	No charge after $25 per visit copay** (Copay waived if admitted)
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No charge
Ambulance	90% after plan deductible ** If not a true emergency, services are not covered
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Contract Year Maximum: 45 days combined No prior hospitalization required	90% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)	
Advanced Radiological Imaging (i.e. MRIs, CAT Scans and PET Scans) **Note:** Associated ancillary charges are subject to the applicable place of service coinsurance level, place of service copay and/or plan deductible (e.g. injections, dye, etc.)	90% after plan deductible
Other Laboratory and Radiology Services:	
Physician's Office Visit	No charge
Outpatient Hospital Facility	90% after plan deductible
Independent X-ray and/or Lab facility	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Short-Term Rehabilitative Therapy Contract Year Maximum: 40 visits for all therapies combined Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after $20 Physician or $25 Specialist per office visit copay No charge if only x-ray and/or lab services performed and billed. **Note:** The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit.
Chiropractic Care Contract Year Maximum: 20 visits for all therapies combined	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
Home Health Care Contract Year Maximum: 120 days	No charge
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	90% after plan deductible No charge
Bereavement Counseling Services Provided as part of Hospice Care Inpatient Outpatient Services Provided by Mental Health Professional	 90% after plan deductible No charge Covered under Mental Health benefit
Maternity Care Services Initial Visit to Confirm Pregnancy **Note:** OB/GYN provider is considered a Specialist. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB or Specialist Delivery - Facility (Inpatient Hospital, Birthing Center)	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed. No Charge No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed No Charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Abortion Includes elective and non-elective procedures	
Physician's Office Visit	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
Inpatient Facility	90% after plan deductible
Outpatient Facility	90% after plan deductible
Physician's Services	90% after plan deductible
Family Planning Services Physician's Office Visit (tests, counseling)	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)	**Note:** Charges billed by a separate independent x-ray/lab facility will be covered under the plan's Laboratory and Radiology benefit
Inpatient Facility	90% after plan deductible
Outpatient Facility	90% after plan deductible
Physician's Services	90% after plan deductible
Physician's Office Visit	No charge after $20 Physician or $25 Specialist per office visit copay

BENEFIT HIGHLIGHTS	IN-NETWORK
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination Services Not Covered include: In-vitro, GIFT, ZIFT, etc. Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc.)	**Note:** Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's Laboratory and Radiology benefit.
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
Surgical Procedure Copay	$200 Surgical Copay
Inpatient Facility	90% after plan deductible
Outpatient Facility	90% after plan deductible
Physician's Services	90% after plan deductible
Organ Transplant *Includes all medically appropriate, non-experimental transplants*	
Office Visit	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
Inpatient Facility	90% after plan deductible
Inpatient Physician's Services	90% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant/per lifetime	No charge (only available when using Lifesource facility)
Durable Medical Equipment **Contract Year Maximum**: Unlimited	No charge
External Prosthetic Appliances **Contract Year Maximum**: $10,000	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Nutritional Evaluation Contract Year Maximum: 3 visits per person Physician's Office Visit	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
Inpatient Facility	90% after plan deductible
Outpatient Facility	90% after plan deductible
Physician's Services	90% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Physician's Office Visit	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed
Inpatient Facility	90% after plan deductible
Outpatient Facility	90% after plan deductible
Physician's Services	90% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK
TMJ Surgical and Non-surgical	
Physician's Office Visit	No charge after $20 Physician or $25 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
Inpatient Facility	90% after plan deductible
Outpatient Facility	90% after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Mental Health/Substance Abuse	
Inpatient Contract Year Maximum 30 days Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: Not Covered	90% no deductible
Outpatient Contract Year Maximum 25 visits	No charge after $25 per office visit copay
Subject to the plan's Outpatient Mental Health/Substance Abuse benefit maximum on a 2:1 basis.	No charge after $25 per visit copay

Managed Medical Benefits

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- for outpatient Mental Health and Substance Abuse services;
- outpatient facility services;
- nonemergency ambulance; or
- transplant services.

GM6000 05BPT16 V6

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

GM6000 CM5
FLX107V126

- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

GM6000 CM6
FLX108V748

- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made for Routine Preventive Care, including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.

GM6000 CM6
FLX108V771

- charges made for or in connection with mammograms for breast cancer screening and diagnosis, as follows: (a) a baseline mammogram for women ages 35 to 39; (b) a mammogram every other year for women ages 40 to 49; (c) an annual mammogram for women age 50 and older; and (d) when ordered by a Physician for women who have a personal history of breast cancer; who have a personal history of biopsy proven breast disease; who have a grandmother, mother, sister or daughter who have had breast cancer; or who have not given birth prior to age 30.
- charges made for or in connection with an annual Papanicolaou screening (Pap test), or more frequently if recommended by a Physician.
- charges for a drug that has been prescribed for the treatment of a life-threatening condition/disease or

chronic/debilitating disease or condition for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the three established reference compendia: (i) the American Medical Association Drug Evaluations; (ii) the American Hospital Formulary Service Drug Information; (iii) the United States Pharmacopeia Drug Information; or (iv) two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use(s) as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. Any Medically Necessary services associated with the administration of a drug will also be covered.

- charges for an annual Chlamydia screening test for insured females age 29 or under.
- coverage for inpatient care following a mastectomy or lymph node dissection until the completion of appropriate time as determined by the Physician in consultation with the patient. Follow-up visits, at home or in the office, will also be covered if deemed to be appropriate by the Physician in consultation with the patient. Follow-up care may be provided by a Physician, a physician's assistant, or a registered professional nurse with experience and training in postsurgical care.

GM6000 CM7
GM6000 CM8
INDEM100V25

- charges for prescription inhalants that are required to enable a person to breathe when suffering from asthma or other life-threatening bronchial ailments. When ordered by the treating Physician, additional inhalers will be covered regardless of the number of days before inhaler refills could be obtained otherwise.
- charges for or in connection with the treatment of autism. Autism is defined as a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.
- charges for general anesthesia, Hospital and Physician expenses for inpatient or outpatient dental procedures when performed: (1) on a child who is seven years of age or younger; or who is developmentally disabled; (2) when a successful result cannot be expected under local anesthesia because of a neurological or other medically compromising condition of the individual; or (3) on a person who has sustained extensive facial or dental trauma.

GM6000 CM6
INDEM101V4

- charges for the treatment of children's cancer for Dependent children who are: (a) diagnosed with cancer prior to their 19th birthday; and (b) enrolled in an approved clinical trial program for the treatment of children's cancer. Approved clinical trial programs are prescription drug clinical trial programs in the state of Georgia, as approved by the Federal Food and Drug Administration or the National Cancer Institute that will:
  - introduce new therapies and regimens which are more cost effective, and test them against standard therapies and regimens.
  - be certified by and will utilize the standards for acceptable protocols established by the Pediatric Oncology Group, Children's Cancer Group, or the Commissioner of Insurance.

Covered Expenses will not include charges provided at no cost by the provider, or charges for treatment under the trial program which would not standardly be covered by CG.

GM6000 CM6
INDEM102V2

- charges for annual ovarian cancer surveillance tests for women age 35 and over at risk for ovarian cancer. Annual ovarian cancer surveillance tests are annual screenings using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. A woman at risk is defined as a woman testing positive for BRCA1 or BRCA2 mutations, or one having a family history with: (a) one or more first or second degree relatives with ovarian cancer; (b) clusters of women relatives with breast cancer; or (c) nonpolyposis colorectal cancer.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 5 or less, for charges made for Child Wellness Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

Excluding any charges for:

- more than one visit to one provider for Child Wellness Services at each of the Approximate Age Intervals, up to a total of 12 visits for each Dependent child;
- services for which benefits are otherwise provided under this Covered Expenses section;
- services for which benefits are not payable according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Wellness Services.

Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years and 5 years.

GM6000 CM6
INDEM103V2

- charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.
- charges made for surgical and nonsurgical treatment of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.

GM6000 05BPT55

The following benefits will apply to insulin-dependent and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for diabetic services consisting of Physician visits upon the diagnosis of diabetes; visits following a Physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; visits when reeducation or refresher training is prescribed by a health care practitioner with authorizing authority; and medical nutrition therapy related to diabetes management.
- charges for diabetic services, supplies and self-management training is conditional upon the person's adherence to the prognosis and treatment prescribed by a Physician.

GM6000 05BPT57

Clinical Trials

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

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- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and postgenetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

GM6000 05BPT2 V1

Home Health Services

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if CG has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

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Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

GM6000 CM34 FLX124V26

    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization. Inpatient Mental Health services are exchangeable with Partial Hospitalization sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

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Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

GM6000 INDEM10 V46 M

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse of or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization.

Inpatient Substance Abuse services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

GM6000 INDEM11 V62 M

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Mental Health and Substance Abuse Residential Treatment.

- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

GM6000 INDEM12 V48 M

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by CG for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

GM6000 05BPT3

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription and necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses,
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and it is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of

improvement.

GM6000 05BPT4

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older and
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

GM6000 05BPT5 (2)

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; and diagnostic evaluations.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility. The following are specifically excluded infertility services:

- Infertility drugs;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

GM6000 05BPT6 V2

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-term Rehabilitative Therapy:

- To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;

If multiple outpatient services are provided on the same day, they constitute one visit.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

You do not need a referral from your Primary Care Physician.

GM6000 05BPT9 (2)

The following limitations apply to Chiropractic Care Services:

- To be covered, all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are considered custodial, training, developmental or educational in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

GM6000 05BPT10

Transplant Services

- charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

All Transplant services, other than cornea, must be received at a CIGNA LIFESOURCE Transplant Network® facility. Cornea transplants are payable when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities. Transplant services received at any other facilities are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food

while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

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Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

GM6000 05BPT2 V2

Prescription Drug Benefits

The Schedule

For You and Your Dependents
This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply at a retail pharmacy or each 90-day supply for maintenance drugs from a retail pharmacy. That portion is the Copayment or Coinsurance.

Copayments
Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Copayments are in addition to any Coinsurance.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Prescription Drugs Generic*drugs on the Prescription Drug List	No charge after $10 per prescription order or refill	In-network coverage only
Brand-Name * drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $25 per prescription order or refill	In-network coverage only
Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $50 per prescription order or refill	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by CG		
Maintenance Prescription Drugs Generic*drugs on the Prescription Drug List	No charge after $20 per prescription order or refill	In-network coverage only
Brand-Name * drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $50 per prescription order or refill	In-network coverage only
Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $100 per prescription order or refill	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by CG		

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for prescription drug Benefits, incurs expenses for charges made by a Participating Pharmacy, for Medically Necessary Prescription Drugs ordered by a Physician, CG will pay that portion of the expenses remaining after you or your Dependent has paid the required Copayment and Deductible shown in the Schedule. Coverage also includes Prescription Drugs dispensed by a Participating Pharmacy for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with an invasive dental procedure.

When you or a Dependent is issued a prescription for a prescription drug as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

Benefits include coverage of both oral and injectable insulin, insulin needles and syringes, glucose test strips and lancets.

Limitations

Each prescription order or refill shall be limited as follows:

- to up to a consecutive 30-day supply, at a Participating retail Pharmacy unless limited by the drug manufacturer's packaging; or
- to up to a consecutive 90-day supply, at a Participating retail Pharmacy for Maintenance Drugs unless limited by the drug manufacturer's packaging; or
- to a dosage and/or limit as determined by the P & T Committee.

Your Payments

Coverage for Prescription Drugs purchased at a Participating Pharmacy is subject to the Copayment and Deductible shown in the Schedule, if applicable.

If two or more prescriptions or refills are dispensed at the same time a Copayment must be paid for each prescription order or refill.

When a treatment regimen contains more than one type of drug and the drugs are packaged together for your, or your Dependent's convenience, a Copayment will apply to each type of drug.

Please refer to the Schedule for the required Copayment and Deductible.

Exclusions

No payment will be made for the following expenses:

- drugs or medications available over the counter that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication other than insulin;
- any drugs that are labeled as experimental or investigational;
- Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than syringes used in conjunction with injectable medications and glucose test strips;
- Norplant and other implantable contraceptive products;
- oral fertility drugs;
- injectable drugs or medicines, including injectable infertility drugs;
- prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products;
- prescription drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;

- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs due to loss or theft;
- medications used to enhance athletic performance;
- medications which are to be taken by or administered to you while you are a patient in a licensed Hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;

- for prescriptions obtained from a Non-Participating Pharmacy; and
- fluoride preps.

Other limitations are shown in the "General Limitations" section.

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Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs through a Participating Pharmacy, you pay only the copayment amount shown in the Schedule at the time of purchase. You do not need to file a claim form.

To obtain the appropriate claim form, you can contact CIGNA Member Services at 800-244-6224 or www.mycigna.com.

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Vision Benefits

The Schedule

For You and Your Dependents

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Vision Benefits	You or Your Dependents Will Pay:	
Examinations Eye Exam every 12 months.	$ 5 per office visit copay	In-network coverage only
Maximum Benefit for: Reimbursement toward purchase of a pair of glasses or contact lenses every 12 months		
Lenses Per pair, one pair per 12 month period:	**This Plan Will Pay**	In-network coverage only
Single Vision	$ 20	
Bifocal	$ 30	
Trifocal	$ 40	
Contact Lenses	$ 75	
Frames Per pair, one pair per 12 month period:	$ 30	

Vision Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for charges made In-Network for one complete eye exam, including basic vision screening, refraction and tonometric testing, CG will pay that portion of the expense remaining after you or your Dependent has paid the required Copayment shown in The Schedule. You do not need a referral from your PCP to access these services.

Expenses incurred for charges made In-Network for the purchase of eyeglasses and contact lenses will be subject to the maximum benefit shown in The Schedule.

Exclusions

The following are specifically excluded from coverage:

- any services or items related to orthoptics or vision training;
- magnification vision aids;
- any nonprescription eyeglasses, lenses or contact lenses;
- any charges for tinting, antireflective coatings, prescription sunglasses or light-sensitive lenses;
- any eye examination required by an Employer as a condition of employment or which an Employer is required to provide under a collective bargaining agreement;
- any eye examination required by law;
- safety glasses or lenses required for employment;
- any eye examination or materials that exceed the frequency limits shown in The Schedule. Other limitations are shown in the "General Limitations" section.

Exclusions, Expenses Not Covered and General Limitations

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication for surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for rhinoplasty, unless due to trauma.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery; or (d) charges made by a Physician for any of the following Surgical Procedures: excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth); intraoral drainage of acute alveolar abscess with cellulitis; removal of impacted wisdom teeth; alveolectomy; gingivectomy, for gingivitis or periodontitis.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training,

vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- treatment by acupuncture.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident

and the charges are incurred while traveling on business or for pleasure.

- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

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Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan.

If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14

As each claim is submitted, CG will determine the following:

- CG's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section.

This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Medicare Eligibles

The Medical Insurance for a person who is eligible for Medicare will be modified as follows:

The amount payable under this plan will be reduced so that the total amount payable by CG and Medicare will be no more than 100% of the expenses incurred. This provision will not apply to a person while Medicare, based on the rules established by the Social Security Act of 1965 as amended, is assuming the role of secondary payer to this plan for that person.

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

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Impact of Medicare on Benefits

Coordination of Benefits With Medicare

Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure.

To prevent duplicate benefit payment, the Plan coordinates with Medicare and any other plan that may cover you and your dependents. The first step in coordination is the determination of which plan is primary – or which plan pays benefits first – and which plan is secondary. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits.

The chart below provides important details related to primary and secondary coverage based on your Medicare status.

If you are retired and…	The Plan will pay…
…age 65, Medicare-eligible and enrolled in Part A and Part B; considering enrolling prior to the month in which you turn 65 to maximize coverage	Secondary benefits starting on the first day of the month in which you turn 65
…age 65, Medicare-eligible and do *not* enroll in Part A and Part B	Primary benefits; however, Plan premium will increase
…age 65 or older and not entitled to Medicare	Primary benefits; however, Plan premium will increase

Right of Reimbursement

The Policy does not cover:

1. Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
2. Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG [or the HealthPlan] under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

GM6000 TRM366

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM15V44

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TRM62

Special Continuation of Medical Insurance

If your insurance is terminated for any reason other than failure to make any required contributions, cancellation of coverage for the class in which you belong, or termination of employment for cause, and if you have been insured for at least 6 consecutive months, you may continue the insurance by paying the required premium to the Policyholder. In no event will the insurance be continued beyond the earliest of the following dates:

- the expiration of three months from the date the insurance would otherwise terminate;
- the last day for which you have paid the required contribution;
- the date you become eligible for similar group coverage;
- the date the group policy terminates or is terminated with respect to the class of employees to which you belong.

When Coverage may be Continued

Certain situations allow you to continue your SHBP coverage.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or up to 18 calendar months for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience
- Family medical reason as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation.

You can apply for continued coverage within 31 days after starting an unpaid leave.

For Dependents

If your insurance is being continued as described above, the insurance for any one of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions, until the date your insurance ceases, or with respect to any one Dependent, the date that Dependent ceases to qualify as a Dependent, whichever comes first.

Conversion Available Following Continuation

The provisions of the section entitled "Medical Conversion Privilege" will apply when the insurance ceases.

GM6000 TER8V-4
TRM120 M

Special Continuation for Employees Age 60 or Older

If you are age 60 or older and your medical insurance is terminated for any reason other than failure to make any required contributions, or cancellation of coverage for the class in which you belong, or terminated for reasons which would cause forfeiture of unemployment compensation, or voluntary termination other than for health reasons, and if you have been insured for at least 6 consecutive months, you may continue the insurance by paying the required premium to the Policyholder.

In no event will the insurance be continued beyond the earliest date below:

- the last day of the period for which the required contribution has been paid;
- the date that you become covered under another group plan;
- the date the group policy is canceled;
- the date you become eligible for Medicare.

Special Continuation Upon Divorce or Death of Employee For Spouse Age 60 or Older and Children

If your Dependent spouse's and children's insurance would otherwise cease because of your death, or because of your divorce or legal separation, and if, at the time of your death, divorce or legal separation your Dependent spouse is 60 years of age or older, your surviving or former spouse may continue Dependent Medical Benefits for himself and any Dependent children subject to the provisions set forth above.

In no event will the insurance be continued beyond the earliest of: the date that your surviving or former spouse becomes covered under another group plan or eligible for Medicare; for any one Dependent, the date that Dependent ceases to qualify as a Dependent; or the date the group policy is canceled.

Notification of Special Continuation

Your Employer will notify you and your Dependents in writing of his right to elect the continuation. Your spouse may elect the continuation by: (a) applying in writing; and (b) sending the required contribution to the Employer within 31 days after the date of mailing of the notice by the Employer.

Conversion Available Following Continuation

The terms of the "Medical Conversion Privilege" section will apply after the person's insurance ceases.

GM6000 TER 5
TRM131V8

Continuing Dependent Coverage at Your Death

In the event of your death, your surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc) and the Plan as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse form and send it to the Plan within 90 days of your death.

Plan Provisions vary for survivors:

Surviving Spouse receives annuity

- Plan coverage may continue after your death
- Premiums will be deducted from annuity
- Spouse sends payments directly to Plan if annuity is not large enough to cover premium

Surviving spouse does not receive annuity

- Plan coverage may continue after your death when spouse was married to you at least one year before death
- Spouse sends payments directly to the Plan
- Coverage ends if surviving souse remarries

Surviving child receives annuity

- Plan coverage may continue for each eligible child receiving an annuity larger than the Plan premium
- Member sends payments directly to Plan if annuity is not large enough to cover premium
- Surviving spouses may continue coverage by sending premiums to the Plan.

Surviving child does not receive annuity and there is no surviving spouse

- Plan coverage may continue under COBRA provisions
- New dependents or spouses *cannot* be added to survivor's coverage
- Dependent child coverage ends when the child becomes ineligible

In the Event of an Active Employee's Death

The benefits available to your survivors will depend on your length of service.

- When your surviving spouse receives an annuity from a qualifying retirement system, your covered survivor(s) can continue Plan coverage if your surviving spouse:
  - Elects to receive his or her benefits as an annuity (versus a lump-sum benefit)
  - Sends the Plan a Retirement/Surviving Spouse Form within 90 days after your death

  Surviving children can continue coverage until they are ineligible under Plan rules – dependents may not be added after your death
- When your surviving spouse does not receive an annuity or when a lump-sum benefits is elected, your survivor(s) can continue coverage through COBRA

See provisions for Eligible Retirees for information on survivor coverage in the event of a retiree's death.

Medical Benefits Extension

During Hospital Confinement

If the Medical Benefits under this plan cease for you or your Dependent, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 3 months from the date your Medical Benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

GM6000 BEX182 V1

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new

Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4

If you Leave your Job

This chart shows how your coverage would be affected if you were to leave your job:

If you have this situation:	You will be affected in this way:
• Leave your job with less than eight years of service • Take another job that does not qualify you for coverage • Move to part-time status • Are laid off	• You can continue coverage for up to 18 months under COBRA provisions. (see below for COBRA provisions)

Leave your job and: • Have at least eight years of service, but less than 10 years	You can continue coverage by: • Submitting the appropriate form(s) within 60 days of when your coverage would end • Paying the full cost of coverage, except Subscribers under the Legislative Retirement System • Providing a statement from your employer verifying your service
Leave your job and: • Have at least 10 years of service, but before minimum age to qualify for an immediate retirement annuity • You leave money in retirement system	You can continue coverage by: • Submitting the appropriate form(s) within 60 days of when your coverage would end • Paying the full cost of coverage until your annuity begins • Paying a lower Member premium once your annuity begins

See provision for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections below titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

FDRL20

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in workhours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the

disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

FDRL21

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with CIGNA;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of (1), (2) or (3) above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer's service area. If the Employer offers another benefit option through CIGNA or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

FDRL22

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;

(b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or

(c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

FDRL23

How Much Does COBRA Continuation Coverage Cost

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

- If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium.
- If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium.
- If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

FDRL24

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or

- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

FDRL25

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Conversion Available Following Continuation

If your or your Dependents' COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled "Conversion Privilege" for more information.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26

Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and

- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TRM191V1

Continuing Coverage Under Family and Medical leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks for specific medical and/or family medical reasons. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, the SHBP will bill you directly for coverage premiums. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation…	The impact is this…
• Choose not to continue coverage while on leave	• Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers. • You must resume coverage when you return to work.
• Open Enrollment period occurs while on leave	• If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment. • If you do not continue coverage while on leave, contact your employer for Open Enrollment information.
• Do not return to work after your leave ends and you have paid your premiums directly to the Plan during your leave.	• You may be eligible to continue your medical coverage through COBRA.

Continuing Coverage During Military Leave

You and your dependents have the right to continue your coverage for up to 18 months with premium payments sent directly to the SHBP.

- If you are an activated military reservist called on an emergency basis, you will pay your employee share of the premium.
- For other military leaves, you will be required to pay the full premium. Also, you will be charged a monthly processing fee.

You may elect to discontinue coverage while on leave. The SHBP will reinstate your coverage when you return from military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Participant's illness or injury that the Secretary of Veterans' Affairs determines was acquired or aggravated during the military leave.

When You Have a Complaint or an Appeal

The following complies with federal law and is effective July 1, 2002. Provisions of the laws of your state may supersede.

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL257

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with the level one appeal decision, you may request a second review of nonurgent care claims. To initiate a level two appeal, follow the same process required for a level one appeal except send this appeal the State Health Benefit Plan Appeals Committee who will administer the Level Two Appeal Process.

State Health Benefit Plan
2 Peach Tree St, NW
40th Floor
Atlanta, GA 30303
Attn: Appeals Committee

For required preservice and concurrent care coverage determinations the Appeal Committee review will be completed within 15 calendar days and for post service claims, the Appeal Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeal Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Appeal Committee meeting, and within the Appeal Committee review time frames above if the Appeal Committee does not approve the requested coverage. The Appeal Committee refers to the organization doing the second level nonurgent care review.

For submitting urgent care appeals at this level, follow the process in Level One Appeal. You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. The Claim Administrator's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL738

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will

not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL261

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL260

Arbitration

This provision does not apply to dental plans.

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of a Member), arising out of or in connection with this Certificate may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Certificate shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Certificate pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Certificate.

GM6000 ARB2

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

DFS940

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependents

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 26 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 26.
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild who lives with you and a child for whom you are the legal guardian.

Benefits for a Dependent child will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

Benefits for a Dependent student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS1794

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

DFS1533

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than the required number of hours a week for the Employer.

DFS1427

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;

- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; and (b) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1748

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;

DFS1815M

Injury

The term Injury means an accidental bodily injury.

DFS147

In-Network/Out-of-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

The term Out-of-Network refers to care which does not qualify as In-Network.

Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)

DFS1694

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The policyholder-selected percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

Additional information about the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1814

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

DFS1813

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS285

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

DFS1910

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

DFS622

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS585

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

DFS1534

Formulary

Formulary means a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by the Provider Organization. This list is subject to periodic review and is amended as required.

DFS1499

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted, either directly or indirectly, to provide prescription services to its insureds.

DFS1497M

Pharmacy & Therapeutics (P & T) Committee

A committee of Provider Organization members comprised of Medical providers, Pharmacists, Medical Directors and Pharmacy Directors, which reviews medications for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates medications for addition to or deletion from the Formulary and may also set dispensing limits on medications.

DFS1500

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (d) injectable insulin.

DFS1498